



NEWBORN SCREENING BENEFITS PRESCRIPTION REQUEST FORM

<input type="checkbox"/> IMMEDIATE MEDICAL NEED	<input type="checkbox"/> NEW
<input type="checkbox"/> RENEWAL	<input type="checkbox"/> ADD <input type="checkbox"/> CHANGE PRESCRIPTION

Date: _____

Client Account #: _____ Benefits Expiration Date: _____

Client's Name: _____

Client's Diagnosis: _____

Applicant Pregnant? YES NO Expected Due Date: _____

DOB: _____ Gender: Male Female **Spanish-Speaking Only** YES NO

Parent/Guardian: _____ Phone #: _____

Home Address: _____ City: _____ Zip: _____

Shipping address if different from above: _____

VENDOR CHANGE: <input type="checkbox"/> Pharmacy or <input type="checkbox"/> Medical Foods Distributors ** Explain change below Current Vendor: _____ (check new vendor below) Reason for change: _____ Date of last order placed with current vendor: _____		
Medical Foods Distributors: Low Protein Foods (\$300 limit) Yes No <input type="checkbox"/> PKU Perspectives <input type="checkbox"/> Cambrooke Therapeutics Inc.	Pharmacy Provider: Aapex Compounding Shop Davila	Services: Office Visits Laboratory

List each of the items in the appropriate category below: **

Medications: _____

Vitamins (\$300 Limit): _____

Dietary Supplements (\$1,800 Limit): _____

Medical Food (Formula) _____

Labs:	Doctors Visits	Diagnostic	Other	# of visits
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** For Change in prescription or new item please list medical necessity

Physician Specialist and Facility: _____

Dietitian/RN: _____ Phone: _____

Email Address: _____ Fax: _____

Dietitian/RN Signature: _____ Date: _____

NBS BENEFITS ONLY: Approved: YES NO Effective Dates: _____ NBS Benefits Staff: _____ Date: _____ The following items/ services are not listed as allowable NBS Benefits list _____ <p style="text-align: center;">NBS Medical Director signature is required if requested benefits or services are not listed in the allowable NBS Benefits List.</p> Approved: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> This Disorder Only <input type="checkbox"/> All Disorders <input type="checkbox"/> This Client Only Reason for Denial: _____ NBS Medical Director: _____ Date: _____
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Send completed form to NBS Benefits Fax: 512-776-7593 or E-mail: NBSbenefits@dshs.texas.gov
 Questions? Call 512-776-2983 or 800-252-8023 ext. 2983